WYOMING

Colorectal Cancer Screening Program

Enrollment Application

February 20, 2009

What Steps Do I Take?

- Read, complete the *Enrollment Application* and sign the *Informed Consent and Release of Medical Information and Affidavit of Wyoming Residency*;
- Include copies of applicant's last year's Income Tax Return; and
- Mail or Fax the above-mentioned information to the WCCSP (address is provided on the *Enrollment Application*).

WCCSP will determine your eligibility to participate. There are a few simple eligibility guidelines. Once the program has determined your eligibility, you will receive your determination letter by mail. If you need more enrollment forms for others in your home or friends or family that is over 50 or if you have any questions please contact us at 866-205-5292 or via e-mail at alice.preheim@health.wyo.gov.

Colon Cancer Terms and Definitions

Colonoscopy - This is a test that looks for polyps in the entire colon. A doctor puts a long, flexible tube inside the anus and in the entire colon to allow him or her to see any polyps inside. Most polyps can be removed during the test. This test is usually done every 10 years or as recommended by your doctor.

Crohn's Disease - Crohn's disease is an ongoing disorder that causes inflammation of the digestive tract, also referred to as the gastrointestinal (GI) tract.

Double-Contrast Barium Enema- This test is conducted in a radiology center or hospital. This procedure involves taking x-rays of the rectum and colon after you are given an enema with a barium solution, followed by an injection of air.

Familial Adenomatous Polyposis (FAP) - Familial means that it runs in families. Each child of an affected parent has a 50% risk of inheriting the disease gene. **Adenomatous** is a type of mushroom-shaped growth or polyp, which may be precancerous. **Polyposis** is a condition where 100 or more polyps can form in the large intestines.

Fecal Occult Blood Test (FOBT) – A test that checks for hidden blood in the stool with a test kit you use at home. The doctor's office or a lab, check the kit for blood when it is returned.

Flexible Sigmoidoscopy – Flexible sigmoidoscopy is conducted at the doctor's office, clinic, or hospital. The doctor uses a narrow, flexible, lighted tube to look at the inside of the rectum and the lower portion of the colon.

Hereditary Non-Polyposis Colorectal Cancer (HNPCC) - Also known as, the Lynch syndrome is an inherited cause of cancer of the bowel.

Inflammatory Bowel Disease (IBD) - Inflammatory bowel disease is the name of a group of disorders that cause the intestines to become inflamed (red and swollen).

Polyp - An abnormal, often precancerous growth of tissue (colorectal polyps are growths of tissue inside the intestine).

Sources for definitions: National Cancer Institute and Centers for Disease Control and Prevention.

2009 Federal Poverty Guidelines

Number of Persons in Family Unit	Poverty Line	250% of Poverty Line
1	$10,830	$27,075
2	$14,570	$36,425
3	$18,310	$45,775
4	$22,050	$55,125
5	$25,790	$64,475
6	$29,530	$73,825
7	$33,270	$83,175
8	$37,010	$92,525
Each additional person, add	$3,740	$9,350

The Wyoming Colorectal Cancer Early Detection Program uses 250% poverty guidelines to determine eligibility. Poverty guidelines are updated annually by the federal government. They are usually released by mid-February of that year. You can find the current poverty guidelines with calculated percentages at http://www.cms.hhs.gov/medicaid/eligibility/

Wyoming Colorectal Cancer Screening Program

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1. All questions must be answered on BOTH SIDES. Please print in black ink.
2. Return this form with the *Informed Consent and Release of Medical Information* and the *Affidavit of Wyoming Residency* to the Wyoming Colorectal Cancer Screening Program.

First Name	Initial	**Last Name**	Maiden Name (if applicable)

Address	**City**	**State**	**Zip**	**Birth Date** / /

Home Phone ( )	**Work Phone** ( )	**Best time to reach you:**

Cell Phone ( )

In case of Emergency:
Contact person: _____
Relationship:_____ Phone: (___)_____
Address:_____
City:_____State:_____ Zip:_____

How did you hear about the program?
☐ Doctor ☐ Friends
☐ Breast & Cervical Program ☐ Radio
☐ Family ☐ Billboard
☐ Community Event ☐ Television
☐ Mailing/Flyer ☐ Magazine
☐ Other healthcare provider ☐ Website
☐ Other_____

What race are you?
☐ American Indian
☐ Black/African American
☐ White ☐Asian ☐Pacific Islander
☐ Unknown
☐ Other_____

Are you of Hispanic origin?
☐Yes ☐No

What is your primary language?
☐English ☐Spanish
☐Other_____

Are you a U.S. Citizen and a Wyoming resident for at least 1 year? ☐ Yes ☐ No

Highest grade in school you completed: *circle one* **0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16+**

What is your household income before taxes?
Monthly Income: $
Yearly Income: $
☐ **Attach previous year's Income Tax Return**

How many people live on this income?

Family History *please refer to page 4 for common screening terms

How many family members (parents, brothers, sisters, children) have been told they have colon cancer or rectal cancer? *(please circle)* 0 1 2 3+ Don't Know

How many of those family members with colon cancer were under the age of 60?
(please circle) 0 1 2 3+ Don't Know

How many family members (parents, brothers, sisters, and children) have been told they have polyps in the colon?
(please circle) 0 1 2 3+ Don't Know

How many of those family members with polyps were under the age of 50? *(please circle)* 0 1 2 3+ Don't Know

(See Other Side)

Wyoming Colorectal Cancer Screening Program
6101 Yellowstone Rd, Ste 259A
Cheyenne, WY 82002
Phone 1.866.205.5292 Fax 307.777.2426

How many family members (parents, brothers, sisters, and children) have been told they have other types of cancer?*(please circle)* 0 1 2 3+ Don't Know
What kind of cancer did they have? _____

Personal History

Have you ever had any of the following tests?

Fecal Occult Blood Test (FOBT) □Yes □No □Don't Know Date ____/____/____
Was your exam positive or negative? □Positive □Negative

Double Contrast Barium Enema (DCBE) □Yes □No □Don't Know Date ____/____/____

***Colonoscopy** □Yes □No □Don't Know Date ____/____/____
Were there polyps removed? □Yes □No □Don't Know

***Sigmoidoscopy** □Yes □No □Don't Know Date ____/____/____
Were there polyps removed? □Yes □No □Don't Know

*If polyps were removed during your colonoscopy or sigmoidoscopy, how did you doctor describe the polyp?
□Normal □Pre-Cancerous □Cancer □Don'tKnow
□Other_____

Have you ever been told by a doctor, nurse, or other health professional that you have had:

Cancer of the colon or rectum	□Yes Date ____/____/____	□No	□ Don't Know
Crohns Disease	□Yes Date ____/____/____	□No	□ Don't Know
Familial Adenomatous Polyposis (FAP)	□Yes Date ____/____/____	□No	□ Don't Know
Hereditary Non Polyposis Colorectal Cancer (HNPCC)	□Yes Date ____/____/____	□No	□ Don't Know
Inflammatory Bowel Disease (IBD)	□Yes Date ____/____/____	□No	□ Don't Know
Ulcerative Colitis	□Yes Date ____/____/____	□No	□ Don't Know

Are you currently under a doctor's care for any of the above conditions? □Yes □No □ Don't Know

Insurance Information *(This does not affect your eligibility for this program; this question is for data purposes only. The WCCSP serves Wyoming residents that are uninsured and underinsured)*
Do you currently have private insurance? □Yes □No
Does your insurance cover the entire cost of a colonoscopy? □Yes □No □Don't Know

Do you have Medicare? □ No □ Yes □ Part A only? □ Part A & B

Primary Care Physician Information
Please tell us who your primary doctor is: _____
Name of clinic: _____ City: _____
Phone: _____

For office use only:
Approved _____ *Denied*_____
*Date*_____ *Date*_____

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Informed Consent and Release of Medical Information

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Colorectal Cancer Screening Program

1. Read **both sides** of this page; and
2. Sign this page and include it with your Enrollment Application.

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I want to be a part of the Wyoming Colorectal Cancer Screening Program. I understand that I must fall within the income guidelines and meet various program criteria in order to be eligible for enrollment. I also understand that in order to take part in the program, I must sign below.

- If I am under 50 years of age, I know I cannot be a part of the program without a written referral by my physician;
- I understand that the program will look at my health history and tell me if I am eligible to participate;
- Based on my health history, I may receive screening and/or health education materials;
- I know that the program will cover the cost of colonoscopy at Wyoming Medicaid rate (based on a WCCSP-approved CPT code set);
- I will talk with the clinic/ hospital about how I am going to pay for any tests or services that are not paid by the WCCSP;
- The program may remind me when it is time for me to go to my screening exams and send me information by mail to help me learn more about my health.
- I understand that the program does not pay for complications, adverse events, or treatment if diagnosed with colon cancer or other conditions such as Crohns Disease or other diseases. The program's staff will assist me in finding the most appropriate treatment resources;
- My doctor, laboratory, clinic, radiology unit, and/or hospital can give the results of my colorectal screening, diagnostic tests, and/or treatment services to the program;
- I understand that the program may follow up with my primary care doctor if my past medical records need to be reviewed;
- My name, address, and/or other personal information will be used only by the program. It may be used to let me know when I need follow up exams. This information may be shared with other organizations as required to locate treatment resources;
- Other information may be used for studies approved by the program and/or The Centers for Disease Control and Prevention for use by outside researchers to learn more about colon health. These studies will not use my name or personal information; and
- To assist me in making the best healthcare decisions, the program may share clinical and other healthcare information including lab results and health history with my healthcare providers.

_____ _____
Signature Date

_____ _____ / _____ / _____
Please Print Name Date of Birth

(See Other Side)

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Affidavit of Wyoming Residency

1. Read this page; and
2. Sign this page and include it with your Enrollment Application.

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Affidavit

I, _____, swear or affirm under
(Please print your name)

penalty of perjury of the laws of the State of Wyoming that (check all that apply)

_____ I am a United States citizen

OR

_____ I am Permanent Resident but not a United States Citizen

_____ I have been a Wyoming Resident for at least 1 year

I understand that this sworn statement is required by law because I have applied for a public benefit. I understand that state law requires me to provide proof that I am lawfully present in the United States prior to receipt of this public benefit and a Wyoming Resident for at least 1 (one) year. I further acknowledge that making a false, fictitious or fraudulent statement or representation in this sworn affidavit is punishable under criminal laws of Wyoming.

_____

Signature

_____ _____

Date **ID or Drivers License #**

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